

How to strengthen primary health care

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ABSTRACT

Realization of health care as primary objective is necessary to strengthen primary health care (PHC). There is a need to build financial viable and sustainable PHC based on rational principles to fulfill the goals of providing quality health services on an affordable and equitable basis and also ensuring fiscal prudence. Health-care leadership, innovations in primary care, family medicine specialists, and effective and accountable health governance are the key steps toward our goal.

Keywords: Family medicine, financial viable, primary health care

Introduction

Primary health care (PHC) as a concept came to existence in independent India on the recommendation of Bhore Committee Report in 1946.^[1] Till now, with the time and developments, many models have been implemented. With a better understanding of disease etiology, pathogenesis, diagnosis, and management, various modifications were done to achieve the goals outlined in Alma-Ata declaration.^[2]

PHC in India has been a great challenge because of its diversity and disparity. From North to South, East to West, rich to poor, urban to rural population, disease prevalence varies significantly. Language, cultural beliefs, social stigmas, literacy rate, and general awareness are few challenges encountered.

The world scenario in the field of primary care has been encouraging. Various models of PHC have been implemented with great success in many developing countries.^[3] The main reason behind their success was greater cooperation from citizens, efficient planning, and execution of programs, support of nongovernmental organization (NGO) and government and social insurance schemes.

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Primary Health Care in India - Current Scenario

The current status of PHC in India is very grim. Apart from low rates of institutionalized delivery and immunization coverage, high maternal and infant mortality rate which is definitely a concern and priority, availability of formal primary care in urban and rural area particularly is virtually nonexistent.^[4]

Public health infrastructure is grossly inadequate to cater health-care demands of 1.28 billion population of India. There are gross shortages of skilled health-care workers at primary care level. Whatever the resources are available, they are either overburden or underutilized. Review of the 11th plan performances shows that despite progress, goals were not achieved. Huge gaps remain in the field of training health-care professional at each level rightly pointed in the 12th 5-year plan.^[5]

In India, a federal country, public health, sanitation, hospitals, and dispensaries are state subjects whereas center shares funds with states depending on needs and also provide grants based on the recommendation of independent body.

According to the United Nations Development Programme's Human Development Report 2014, in a set of 187 countries,

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How to cite this article: Kumar P. How to strengthen primary health care. J Family Med Prim Care 2016;5:543-6.

Access this article online

Quick Response Code:



Website:
www.jfmpc.com

DOI:
10.4103/2249-4863.197263

India ranked 135th on the human development index, life expectancy at birth was 66.4 years, under-five mortality rate was 56/1000 live births, and maternal mortality ratio was 200 deaths/100,000 live births, still far behind millennium development goals.

An Overview of Current Challenges and Weaknesses

According to the 12th 5-year plan (2012–2017) document, there have been substantial progresses despite which health-care system suffers from few weaknesses that are availability of health-care services from public and private sectors taken together. Qualities of health-care services are not uniform throughout public and private sector which may be due to lack or inadequately enforced regulatory standards. Affordability of health care is a serious problem as out-of-pocket (OOP) expenditure results in a high financial burden on families. It has been reported that more than 40% of all patients admitted to hospital have to borrow money or sell assets, including inherited property and farmland, to cover expenses,^[6] and 25% of farmers are driven below the poverty line by the costs of their medical care.

Currently, only small percentage of population is covered by health insurances. There is rising burden of noncommunicable diseases. Based on mortality due to noncommunicable diseases, projected cumulative loss for 2006–2015 was USD 237 billion.^[7]

Current set goals outlined in the 12th 5-year plan are to achieve reduction of maternal mortality rate to 100, reduction of infant mortality rate to 25, reduction of total fertility rate to 2.1, prevention and reduction of under-nutrition in children under 3 years to half of the National Family Health Survey-3 (2005–2006) levels, prevention and reduction of anemia among women aged 15–49 years to 28%, raising child sex ratio in the 0–6 years age group from 914 to 950, prevention and reduction of burden of communicable and noncommunicable diseases (including mental illnesses) and injuries, reduction of poor households' OOP expenditure.^[5]

These goals are realistic and strengthening PHC would be major step toward achieving such goals. It needs effective planning and future roadmap to reach the target. PHC forms the anchor around which entire health-care delivery system is organized. This was evident from the recommendation by the High-Level Expert Group on Universal Healthcare appointed by the government of India to allocate 70% of health-care budget for PHC.^[3]

A Health-care Model for Future

PHC aims to provide quality and comprehensive health care in a cost-effective and equitable manner and is the foundation for health systems strengthening. Innovations in the field of health care to reduce health-care expenditure with quality care are the need of hour. Planning and management is necessary to reduce wastage of public funds and resources. Various reports

have shown significant wastage of medicines and health-care equipment because of poor planning.^[8] Preventive care, chronic disease management, and diagnostic triage with control of hospital referral should be the areas of major concern.

Skill development

Quality health care needs skilled health-care workers. Proper training of PHC workers should be done at recognized centers with regular appraisal and incentives. There is a need to upgrade the role of the Accredited Social Health Activist and Urban Social Health Activist workers by training to meet the growing health-care demands. Research should be taken up to provide evidence-based guidelines on an Indian perspective to bring uniformity in management. Family medicine is a specialty which takes care from womb to tomb and from pediatrics to geriatrics. Their role must be defined in PHC and to meet demand of shortage of doctors family medicine training should be started in medical colleges.

Immunization coverage

The current immunization status is at a low level of 64%. Comparing with neighboring countries for instance diphtheria, pertussis and tetanus (DPT) immunization, coverage in India is 72% whereas in Nepal its 82% Bangladesh 95% and Sri Lanka had 99% which correlates with infant mortality rate.^[9] To provide adequate immunization by ensuring maintenance of cold chain, community participation, awareness of parents immunization coverage can be improved and bring down infant mortality rate. There is a need to bring adult immunization also in focus as gradually longevity is increasing and so is age-linked morbidities.

Accountability, audit, and appraisal

To make health care a financial viable, there is a need to be accountable to both government which is provider and to the common public who are recipients. The annual audit may not only give an idea about wastage of resources but also make us aware of ground realities. Consumption of resources, efficient delivery, and for better outcome regular appraisal should be done.

Innovations in primary health care

In the current era of information technology, Aadhar card can play a major role in shaping the future of PHC. All the patients coming to the primary health center can be enrolled by their Aadhar number. Significant medical and surgical history can be updated in the database. Investigation done through government laboratories also can be tracked through Aadhar number. This not only will reduce the expenditure but also will make the health care delivery faster.

In case of maternity and child health, Aadhar number can be used for booking and tracking their progress. To reduce maternal and infant mortality rate, regular maternal and fetal surveillance is required. With E-database tagged with Aadhar number, even mobile populations can also be checked and managed. This will prove a major step ahead in strengthening PHC.

In cases of outbreaks, epidemiological studies are very useful in prevention and management. Electronic database of the population affected may give an idea about predisposing factors, age groups at risk, and spread of outbreak. Such innovations may help in planning strategies to prevent its spread and early management. Subsequently, it will reduce unnecessary health-care burden and stress on health-care workers.

Telemedicine may link PHC to tertiary health care and may be useful in remote areas. Community participation through Panchayati Raj in rural areas and local group in urban areas may help in smooth health care delivery. Formation of groups like “alcoholic anonymous” may reduce illicit drug, nicotine, and alcohol abuse. Nutrition, clean water, and sanitation are also vital in reducing morbidity and improving health.

Increase public expenditure on health

There has been just marginal increase in public expenditure on core health from 0.93% of gross domestic product (GDP) in 2007–2008 to 1.04% during 2011–2012. However, the total expenditure taking both public, private, and household OOP expenditure was about 4.1% of GDP in 2008–2009. This shows the burden of health care in India which can be taken care of by increasing public spending and reaching the target level of 2%–3% of GDP on health expenditure. Comparing public health expenditure of India with other countries moving toward the goal of universal health coverage, increased public health-care expenditure may be the best option to move ahead [Figures 1 and 2].^[10]

Social insurance schemes

Social insurance schemes have been successful in reforming health-care systems in countries such as Brazil, Thailand, and South Korea.^[11] These models have been effective in not only reducing infant and maternal mortality rates but also lead to decrease in OOP expenditure. There are three central government health insurance schemes: Central Government Health Schemes, Employee State Insurance Scheme, and Rashtriya Swasthya Bima Yojana. Integration of such public schemes will lead to effective utilization of resources and improved health-care delivery at affordable cost.

Bridging the gaps

There is shortage of health-care professionals and adequate infrastructure. It hampers efficient health-care delivery at primary care level. These gaps can be bridged by effective utilization of funds, public–private partnership, affordable technologies, and training.^[12]

Role of international organizations and nongovernmental organization

There is a need to channelize technical and financial aid from WHO, UNICEF, World Bank, and other funding agencies toward strengthening PHC. NGOs may act as medium to disseminate and utilize such resources. This has also been recommended in declaration of Alma-Ata.^[2]

Conclusion

To strengthen PHC, realization of health care as primary objective is necessary. There is a need to build financial viable and sustainable PHC based on rational principles to fulfill the goals of providing quality health services on an affordable and equitable basis and also ensuring fiscal prudence [Figure 3]. Health-care leadership, innovations in primary care, family medicine

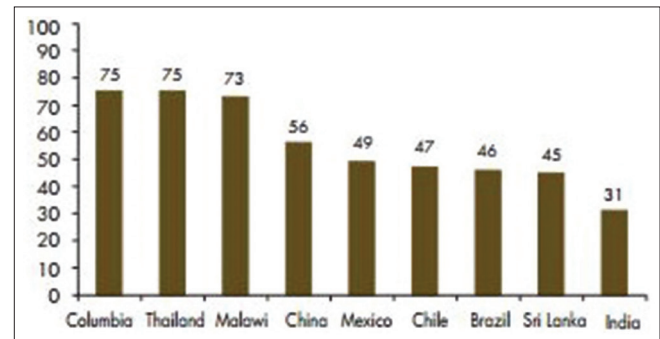


Figure 1: Per capita public spending in purchasing power parity (National Currency Unit/US\$), 2011 (Source: WHO Global Health Expenditure Database)

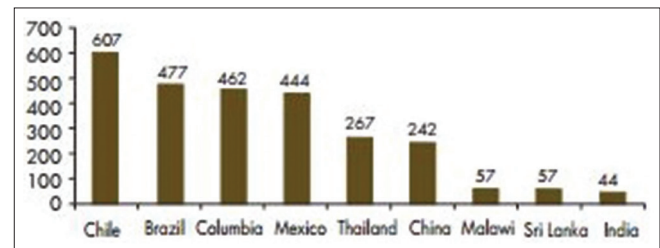


Figure 2: Share (%) of public spending in total health spending, 2011 (Source: WHO Global Health Expenditure Database)



Figure 3: Strengthening wheels of primary health care

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Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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